CBT Principles and Techniques for Stress-Related Reactions

NEW ORLEANS MENTAL HEALTH
EDUCATION AND TRAINING PROJECT
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Overview

- Introduction
- Contextual Analysis of Trauma
- Evidence-based Practice
- Cognitive Behavioral Therapy
- CBT for Stress-Related Reactions
  - Depression & Anxiety (PTSD)
- Clinician Self-Care
- Resources

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Contextual Analysis of Trauma

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Contextual-Ecological Perspective on Trauma

- Interpersonal contexts of traumatization
  - The role of "trauma reminders"
    - Stimuli that elicit or prompt symptoms and problem behaviors.
    - Disclosure of traumatic experience is an interpersonal event.
  - The role of "invalidating environment"
    - One in which a person's expression of his/her private experience is responded to with "erratic, inappropriate, and extreme responses" (Linehan).
      - "Just forget it" or "Move on with your life"

From *Cognitive-Behavioral Therapies for Trauma.* Guilford. 4

Contextual-Ecological Perspective on Trauma

- Larger environmental contexts of traumatization
  - Issues of gender, ethnic minority membership, and aging are examples of large-scale influences on what treatment experiences are offered
  - Such chronic stressors have a demoralizing impact
  - Mass media depictions of traumatic events and the experience of survivors—often too "clean"
    - Creates a social climate in which victims of trauma are surprised by the intensity of their reactions

From *Cognitive-Behavioral Therapies for Trauma.* Guilford. 5

Contextual-Ecological Perspective on Trauma

- The contexts of treatment
  - Theories of traumatization AND therapist behaviors (and treatment systems themselves) are part of the larger environment in which a victim must adapt
  - "Medical model" of human difficulties.
  - "Disorders" treated by "mental health" specialists
    - Reification of posttrauma problems as PTS…DISORDER!
    - Treatment delivered in a manner and environment far removed from that normally encountered by client
    - And yet, we say it's a "Normal response to abnormal circumstances"

From *Cognitive-Behavioral Therapies for Trauma.* Guilford. 6

Evidence-Based Practice

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Evidence-based Practice

- Evidence-based practice is:
  - "A total process beginning with knowing what clinical questions to ask, how to find the best practice, and how to critically appraise the evidence for validity and applicability to the particular care situation. The best evidence then must be applied by a clinician with expertise in considering the client's unique values and needs. The final aspect of the process is evaluation of the effectiveness of care and the continual improvement of the process"

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APA Presidential Task Force on Evidence-Based Practice

- "Evidence-based practice (EBP) in psychology is the integration of the best available research with the clinical expertise in the context of patient characteristics, culture, and preferences."
- "The purpose of EBP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention.

From *Evidence-Based Practice in Psychology*. May-June 2006. American Psychologist..

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EBP vs. Empirically Supported Tx

- EBP is a more comprehensive concept.
- Empirically Supported Treatments (ESTs) start with treatment and ask whether it works for a *specific* disorder/problem under *specified* circumstances.
- EBP starts with the client and asks what research evidence will assist in achieving the best outcome.

From *Evidence-Based Practice in Psychology*. May-June 2006. American Psychologist..

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EBP vs. Empirically Supported Tx

- ESTs are specific psychological treatments that have been shown to be efficacious in controlled clinical trials.
- EBP encompasses a broader range of clinical activities
  - e.g., assessment, case formulation, therapy relationships
- EBP articulates a decision-making process for integrating multiple streams of research evidence into the intervention process.

From *Evidence-Based Practice in Psychology*. May-June 2006. American Psychologist..

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3 Major Components of EBP

1. Best available research
2. Clinical expertise
3. Patient characteristics

From *Evidence-Based Practice in Psychology*. May-June 2006. American Psychologist..

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3 Major Components of EBP

- Best available research
  - "Scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as clinically relevant results of basic research in psychology and related fields."
  - APA endorses multiple types of research evidence:
    - Efficacy
    - Effectiveness
    - Cost-effectiveness
    - Cost-benefit
    - Epidemiological
    - Treatment utilization
  - Researchers are practitioners must join together to ensure that the research is both clinically relevant and internally valid.

From *Evidence-Based Practice in Psychology.* May-June 2006. American Psychologist..

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3 Major Components of EBP

- Clinical expertise
  - Essential for identifying and integrating the best *research evidence* with *clinical data* (e.g., client information gathered over the course of treatment)…
  - …in the context of the *patient's characteristics and preferences*…
  - …to deliver services that have the *highest probability* of *achieving the goals* of therapy.

From *Evidence-Based Practice in Psychology.* May-June 2006. American Psychologist..

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3 Major Components of EBP

- Patient characteristics
  - "Psychological services are most likely to be effective when they are responsive to the client's specific…
    - problems,
    - strengths,
    - personality,
    - sociocultural context,
    - and preferences."
      - (Norcross 2002)

From *Evidence-Based Practice in Psychology.* May-June 2006. American Psychologist..

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The Status of Evidence-Based Psychological Intervention

- CBT is the only psychosocial treatment meeting criteria as an empirically supported treatment for many depressive and anxiety disorders.
- Yet, only a minority of clients receive this intervention.
- We know little about type of psychological treatment clients receive; evidence suggests that evidence-based treatments are not typically administered
  - (Weissman & Sanderson, 2002)

From *Treating Generalized Anxiety Disorder* by Rygh & Sanderson. Guilford Press.

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The Status of Evidence-Based Psychological Intervention

- E.g., for GAD, only 34% of patients reported ever receiving cognitive or behavioral treatments.
  - (Goisman & Keller, 1999)
- We can suspect that the same is true for other commonly encountered emotional disorders
  - MDD, OCD, Bulimia, social phobia, etc.

From *Treating Generalized Anxiety Disorder* by Rygh & Sanderson. Guilford Press.

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The Status of Evidence-Based Psychological Intervention

- Seeing an increase over time?
  - Not really. Even though there is a growing body of research and emphasis on EBP in recent years.
- So?
  - Gap between those treatments found to be effective in research trials and those practiced in the "real world."

From *Treating Generalized Anxiety Disorder* by Rygh & Sanderson. Guilford Press.

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The Status of Evidence-Based Psychological Intervention

- Why be concerned?
  - Lack of availability of many effective treatments.
  - May have disastrous impact on viability of psychotherapy as the health care system evolves.
  - Penetration of managed care, and the development & proliferation of practice guidelines have raised the stakes of accountability.

From *Treating Generalized Anxiety Disorder* by Rygh & Sanderson. Guilford Press.

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The Status of Evidence-Based Psychological Intervention

- Why be concerned? (cont.)
  - The failure to train practitioners in EBP may lead to the fall of psychotherapy as a first-line effective treatment, despite data supporting its efficacy.
  - Since managed care organizations and federal guidelines cannot rely on delivery of treatments that are not widely available, these treatments are given secondary status.
  - Without training, where do MH providers fall in the new health care scheme?

From *Treating Generalized Anxiety Disorder* by Rygh & Sanderson. Guilford Press.

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Why CBT?

- "CBT methods for stress-related responses to trauma and other consequences of traumatization have been tested in more studies than any other form of treatment."
  - (Foa & Meadows, 1997)
- Specificity of intent
  - Treatment elements designed to affect specific aspects of responding
- Future studies still needed to address problem areas that have been difficult to change.
  - (e.g., emotional numbing)

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Cognitive Behavioral Therapy

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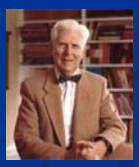
History of CBT

- 1950s and early 60s, behavior therapy called attention to how environment can reinforce desired behaviors.
- Researchers then became interested in the role of cognition on behavior.
- The field of CBT grew out of this interest, primarily due to the work of Drs. Albert Ellis and Aaron Beck.
- Now, one of the most widely practiced forms of psychotherapy in the world.
  - Leading mandated treatment in the UK.



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Overview of CBT

- CBT involves a consideration of 5 components to any problem.
  1. Cognition (thoughts)
  2. Mood (emotions)
  3. Physiological reactions (e.g., physical sensations)
  4. Behavior
  5. Environment

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Overview of CBT

- CBT presumes that cognitions mediate mood, behavior, and physiological reactions in response to the environment.
  - Cognitions include:
    - Perceptions
    - Beliefs
    - Self-talk
- Dysfunctional (though not necessarily *inaccurate* or *distorted*) cognitions contribute to maladjustment.

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Overview of CBT

- CBT therapist helps clients become aware of the relationships among the 5 areas. For example:
  - To recognize how certain negative, unhelpful, or unrealistic thoughts can generate distress:
    - Uncomfortable physical sensations
    - Maladaptive behavior
    - Seemingly uncontrollable emotions that appear out of proportion to the situation.
  - To understand how social and physical aspects of the environment can contribute to distress.

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Overview of CBT

- Once clients understand these connections, more helpful coping strategies are developed.
- 3 main categories of coping strategies:
  - Problem solving
  - Social skills and support
  - Cognitive restructuring

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Overview of CBT

- Clients may need to take concrete action to solve the problem, learn new skills, or develop a broader network of support.
- Cognitive restructuring requires more than positive thinking.
  - Must learn to recognize…
    - common cognitive errors,
    - dysfunctional thoughts,
    - and cognitive tendencies related to schemas by which information/experience is organized.

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Concerns About CBT

- The structure of sessions/Tx course:
  - "The patient will not like it."
  - "The patient will feel controlled."
  - "It will make me miss important content."
  - "It is too rigid."
- Just as for clients in CBT, therapists are urged to test these ideas directly.
- Therapists who initially feel awkward, find that the process gradually becomes second nature.

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Principles of Cognitive Therapy

1. CBT is based on ever-evolving formulation of pt's problems in cognitive terms
   - Current thinking
   - Problematic behaviors
   - Precipitating factors
   - Developmental events
   - Enduring patterns of interpreting

From *Cognitive Therapy: Basics and Beyond.* Guilford.

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Principles of Cognitive Therapy

2. CBT requires a sound therapeutic alliance.
   - Warmth
   - Empathy
   - Caring
   - Genuine regard
   - Competence
   - Feedback
- So, does the therapeutic relationship matter?

From *Cognitive Therapy: Basics and Beyond.* Guilford. 31

Principles of Cognitive Therapy

3. CBT emphasizes collaboration and active participation.
   - Teamwork
   - Leading-partner to partner relationship
   - Treatment goals
   - Homework
   - Agenda setting

From *Cognitive Therapy: Basics and Beyond.* Guilford. 32

Principles of Cognitive Therapy

4. CBT is goal oriented and problem focused.
   - Enumerate problems
   - Set specific goals
   - Identify & resolve obstacles to goals
   - Develop/teach problem solving strategies

From *Cognitive Therapy: Basics and Beyond.* Guilford. 33

Principles of Cognitive Therapy

5. CBT initially emphasizes the present
   - Current problems
   - Specific current situations that are distressing
   - Shift to past in 3 circumstances:
     1. client's predilection to do so
     2. Work toward current problems shows little change
     3. When an understanding of how dysfunctional ideas originated is deemed important

From *Cognitive Therapy: Basics and Beyond.* Guilford. 34

Principles of Cognitive Therapy

6. CBT is educative, aims to teach the client to be own therapist & emphasizes relapse prevention
   - Nature & course of d/o
   - Process of cognitive therapy
   - Cognitive model
   - How to set goals, identify & modify thoughts, beliefs, and behaviors
   - Record in writing and review what is learned in session

From *Cognitive Therapy: Basics and Beyond.* Guilford. 35

Principles of Cognitive Therapy

7. CBT aims to be time-limited
   - Typically 4-14 sessions for anxiety & depression
   - Provide symptom relief
   - Facilitate remission of d/o
   - Resolve most pressing problems
   - Teach tools to avoid relapse
   - Session weaning and "booster" sessions

From *Cognitive Therapy: Basics and Beyond.* Guilford. 36

Principles of Cognitive Therapy

8. CBT sessions are structured
   - Check mood
   - Brief review of week
   - Set an agenda
   - Elicit feedback about last session
   - Review homework
   - Discuss agenda
   - Set new homework
   - Summarize
   - Seek feedback about current session

From *Cognitive Therapy: Basics and Beyond.* Guilford. 37

Principles of Cognitive Therapy

9. CBT teaches clients to identify, evaluate, and respond to dysfunctional thoughts & beliefs
   - "What's going through your mind?"
   - Examining the evidence for/against thought
   - Socratic questioning
   - Collaborative empiricism
   - Guided discovery

From *Cognitive Therapy: Basics and Beyond.* Guilford. 38

Principles of Cognitive Therapy

10. CBT uses a variety of techniques to change thinking, mood, and behavior
    - Will vary based on needs/problems of client
      - Nature of difficulties
      - Goals
      - Therapeutic bond
      - Motivation to change
      - Previous experience w/ therapy
      - Preferences for treatment
    - Emphasis of Tx will vary by disorder

From *Cognitive Therapy: Basics and Beyond.* Guilford. 39

Developing As A Cognitive Therapist

- 3 stages of development
  - (Presupposing your proficiency in demonstrating empathy, concern, and competence to patients.)
  1. Learning
  2. Integrating
  3. Refining and varying

From *Cognitive Therapy: Basics and Beyond.* Guilford. 40

Developing As A Cognitive Therapist

- STAGE 1
  - Learn to structure the session
  - Use basic techniques
  - Learn basic skills of conceptualizing a case in cognitive terms based on an intake evaluation and data gained in session

From *Cognitive Therapy: Basics and Beyond.* Guilford. 41

Developing As A Cognitive Therapist

- STAGE 2
  - Begin integrating your conceptualization with your knowledge of techniques.
  - Strengthen your ability to understand the flow of therapy and identify critical goals of therapy.
  - Become more skillful at conceptualizing patients, refining your conceptualization during the therapy itself, and using your conceptualization to make decisions about interventions.
  - Become more proficient in selecting, timing, and implementing appropriate techniques.

From *Cognitive Therapy: Basics and Beyond.* Guilford. 42

Developing As A Cognitive Therapist

- STAGE 3
  - More automatically integrate new data into the conceptualization.
  - Refine your ability to make hypotheses to confirm or disconfirm your view of the patient.
  - You vary the structure and techniques of basic cognitive therapy as appropriate, particularly for cases such as personality disorders.

From *Cognitive Therapy: Basics and Beyond.* Guilford.

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Culturally Responsive CBT

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Culturally Responsive CBT

- Begins with therapist's attention to own biases because of inexperience or knowledge gaps.
  - Which we sometimes call "ignorance"
  - This work is personal and an ongoing process.

From *Culturally Responsive Cognitive Behavioral Therapy.* American Psychological Association.

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Culturally Responsive CBT

- The development of *cultural schemas* is important so that client-specific information can be appropriately considered and incorporated into Tx.
  - Clients should *not* be expected to educate the therapist about the broader social and cultural meanings of their identities.
  - Therapists *will* need to obtain information from clients regarding each client's unique personal experience of their culture.

From *Culturally Responsive Cognitive Behavioral Therapy*. American Psychological Association. 46

Culturally Responsive CBT

- CBT is built on being:
  - Nonjudgmental
  - Focusing on strengths
  - Empowering clients
  - Educating clients; thereby reducing stigma
  - Reliance on the scientific method
- But, that doesn't mean CBT is value-neutral!

From *Culturally Responsive Cognitive Behavioral Therapy*. American Psychological Association. 47

Culturally Responsive CBT

- CBT is as value-laden any other psychotherapy
  - Emphasis on:
    - Cognition
    - Logic
    - Verbal skills
    - Rational thinking
- These characteristics strongly favor dominant cultural perspectives including definitions of rationality
  - e.g., can lead to an underemphasis of spirituality.

From *Culturally Responsive Cognitive Behavioral Therapy*. American Psychological Association. 48

Culturally Responsive CBT

- Also, the focus on changing one's self may not be consistent with cultural influences that restrict a person's ability to make change.
- May result in blaming clients for environmentally-based problems.

From *Culturally Responsive Cognitive Behavioral Therapy*. American Psychological Association.

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The CBT Model

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The Cognitive Model

- Hypothesizes that peoples emotions and behaviors are influenced by their perception of events.
- Not a situation in and of itself that determines what people feel, but rather the way in which they *construe* a situation.
- So, the way people feel is associated with the way in which they interpret and think about a situation.
- *This situation itself does not directly determine how they feel.*

From *Cognitive Therapy: Basics and Beyond*. Guilford.

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The Cognitive Model

- There are a number of levels of thinking.
- One level focuses on what you are doing/what is happening.
- On another level, you sometimes have quick, evaluative thoughts…
  - these are called ***automatic thoughts***.
- They are not the result of deliberation or reasoning; they are often rapid and brief.

From *Cognitive Therapy: Basics and Beyond.* Guilford. 52

The Cognitive Model: Automatic Thoughts

- Likely not aware of ATs.
- More likely to notice the emotion that follows.
- As a result, we often accept our ATs as true, without critique.
- One can learn to identify ATs.
- Once identified, the validity of ATs can be evaluated.
- Once interpretations are found erroneous and corrected, mood often improves.

From *Cognitive Therapy: Basics and Beyond.* Guilford. 53

The Cognitive Model: Automatic Thoughts

- Likely not aware of ATs.
- More likely to notice the emotion that follows.
- As a result, we often accept our ATs as true, without critique.
- One can learn to identify ATs by attending to shifts in affect.
  - "What was going through my mind just then?"
- Once identified, the validity of ATs can be evaluated.
- Once interpretations are found erroneous and corrected, mood often improves.

From *Cognitive Therapy: Basics and Beyond.* Guilford. 54

The Cognitive Model: Automatic Thoughts

- Where do ATs come from?
- Why do different people construe the same event differently?
- Why does the same person interpret an identical event differently at one time than at another?
- The answer has to do with more enduring cognitive phenomena:
  - ***Beliefs***

From *Cognitive Therapy: Basics and Beyond.* Guilford. 55

The Cognitive Model: Beliefs

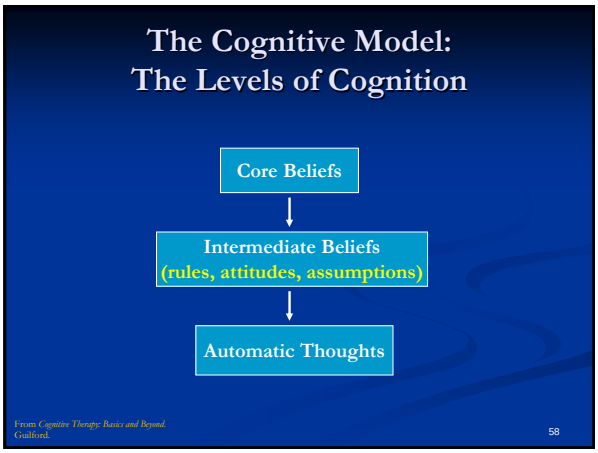
- Beginning in childhood, people develop certain beliefs about themselves, other people, and their worlds.
- The most central are ***core beliefs***.
  - Often so fundamental and deep, they are often not articulated to the self.
    - Accepted as "just the way things are": Absolute truths.

From *Cognitive Therapy: Basics and Beyond.* Guilford. 56

The Cognitive Model: Beliefs

- Core beliefs
  - The most *fundamental* level of belief
  - They are *Global*, *rigid*, and *overgeneralized*.
- Automatic Thoughts
  - The actual words or images that go through one's mind.
  - They are situation specific and may be considered the most *superficial* level of cognition.
- Intermediate beliefs
  - Attitudes, rules, and assumptions that exist between core beliefs and automatic thoughts.

From *Cognitive Therapy: Basics and Beyond.* Guilford. 57


The Cognitive Model:
The Levels of Cognition
Core Beliefs
Intermediate Beliefs
(rules, attitudes, assumptions)
Automatic Thoughts
From Cognitive Therapy: Basics and Beyond. Guilford.
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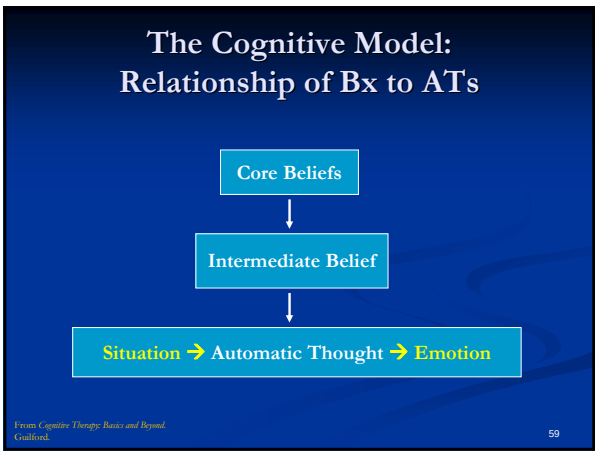
The Cognitive Model:
Relationship of Bx to ATs
Core Beliefs
Intermediate Belief
Situation → Automatic Thought → Emotion
From Cognitive Therapy: Basics and Beyond. Guilford.
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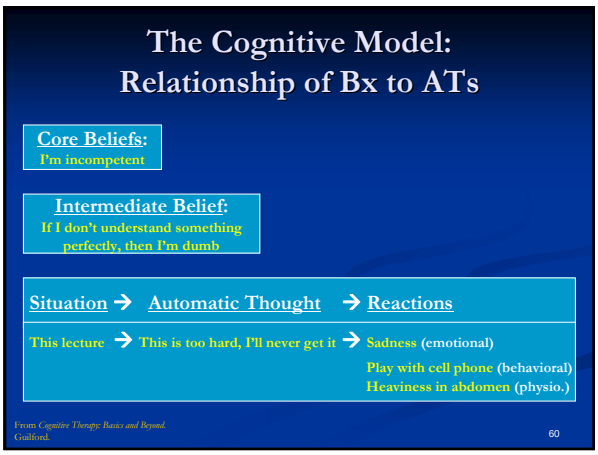
The Cognitive Model:
Relationship of Bx to ATs
Core Beliefs:
I'm incompetent
Intermediate Belief:
If I don't understand something perfectly, then I'm dumb
Situation → Automatic Thought → Reactions
This lecture → This is too hard, I'll never get it → Sadness (emotional)
Play with cell phone (behavioral)
Heaviness in abdomen (physio.)
From Cognitive Therapy: Basics and Beyond. Guilford.
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Core Beliefs

- Information-Processing Model
  - Very helpful in explaining to clients why they believe their core beliefs so strongly
  - But also why the core beliefs may not be (completely) true.

From *Cognitive Therapy for Challenging Problems*. Guilford.

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Information-Processing Model

…because I'm still not over it.

Adapted from *Cognitive Therapy for Challenging Problems*. Guilford.

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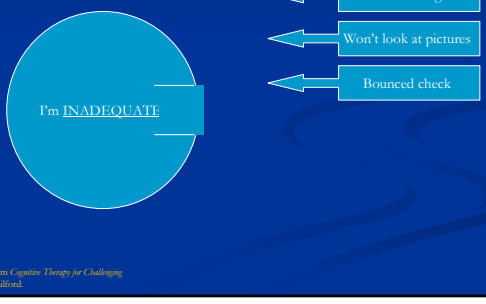
Information-Processing Model



Adapted from *Cognitive Therapy for Challenging Problems*. Guilford.

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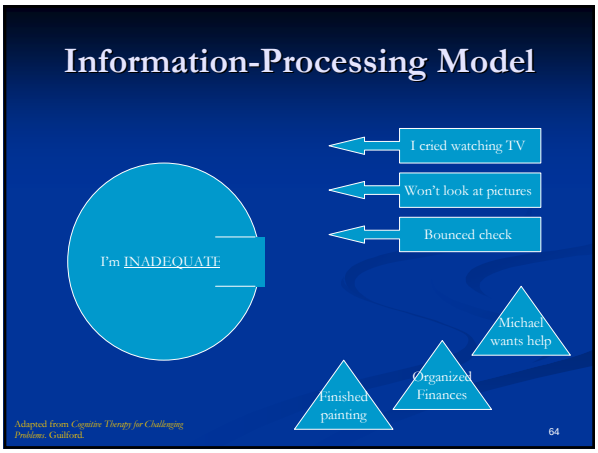

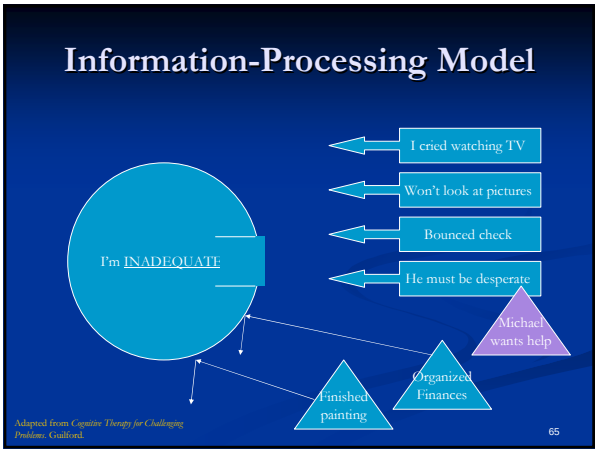

Format of CBT Sessions

- Brief update and mood check
  - Meds, AOD use
- Bridge from previous session
- Setting the agenda
- Review of homework
- Discussion of issues on agenda
  - Setting new homework
  - Periodic summaries
- Finally summary and feedback

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Success with Homework

1. Tailor the assignment to the individual
   - 90-100% sure the client can and will do the HW
   - Error on the side of making it too easy than hard.
2. Provide a rationale for how and why the HW might help.
3. Set HW collaboratively; seek input and agreement.
4. Make HW a no-lose proposition.

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Success with Homework

5. Begin the assignment in session (when possible).
6. Help set up reminders to complete the HW.
7. Anticipate possible problems; do covert rehearsal when indicated
   - "Imagine you're about to sit at your desk on Saturday…"
8. Prepare for a possible negative outcome (when applicable).

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CBT for Stress-Related Reactions

Depression and Anxiety/PTSD

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CBT for Depression

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Sample Symptoms of Depression

- Affective
  - Depressed mood
  - Irritable mood
  - Anhedonia
  - Low motivation
- Cognitive
  - Feelings of worthlessness
  - Excessive guilt
  - Impaired concentration
  - Difficulty making decisions

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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Sample Symptoms of Depression

- Vegetative
  - Lack of interest in usual activities
  - Loss of appetite or increased
  - Weight loss or gain
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation
  - Fatigue
  - Low energy
- Other
  - Suicidal ideation
    - Previous attempts
    - Plan
  - Thoughts of death
  - Chronicity of symptoms
  - Prior episodes

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 73

Behavioral Factors of Depression

1. Loss of rewards
   - Loss of work, friendships, intimacy, community?
2. Decrease of rewarding behavior
   - Fewer activities that used to be rewarding, withdrawal
3. Lack of self-reward
   - Self-praise, hesitant to spend money. Often related to self-worth.
4. Skill deficits
   - Social skills, problem-solving skills, assertiveness

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 74

Behavioral Factors of Depression

5. New demands
   - Moving, new job, parenthood, break-ups, new friends
6. Situations in which the person feels helpless
   - Unrewarding jobs, dead-end relationships
7. Situation of continual punishment
   - Spending time with people who criticize or hurt in various ways

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 75

Cognitive Factors of Depression

- Dysfunctional automatic thoughts
  - Mind reading, labeling, fortunetelling, catastrophizing, all-or-nothing thinking, negative filtering
- Maladaptive assumptions
  - What you think you should be doing
  - The rules by which you think you have to live
- Negative self-concepts
  - Focus on shortcomings, exaggerate them, and minimize positive qualities.
  - See self as unlovable, ugly, stupid, weak, or even evil.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 76

General Tx Plan for Depression

- Assessment
  - Cognitive, behavioral, and interpersonal assessment
  - Tests and other evaluations
  - Evaluation of suicidal risk
  - Medication consideration/evaluation
- Socialization to treatment
- Establishment of goals
- Behavioral activation and other behavioral interventions
- Cognitive interventions
- Inoculation against future depressive episodes
- Phasing out therapy

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 77

Session 1

- Assessment
  - Presenting problems
  - Cognitive, behavioral, interpersonal deficits
  - Impairment in social, educational, and occupation functioning
  - Intake measures
  - Comorbid conditions
  - Suicidal risk
  - Substance use (detox?)
  - Need for medications
- Homework
  - Reading on CBT, Depression (*Mind Over Mood*, *Feeling Good*)

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 78

Session 2

- Socialization to treatment
  - Educate about diagnosis, list of treatment goals, handouts on CBT & depression, evaluate homework.
- Behavioral interventions
  - Identify behavioral targets, instruct in reward planning & activity scheduling, encourage increasing self-reward & decreasing passive/asocial behavior, evaluate/treat insomnia

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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Session 2

- Cognitive interventions
  - Train in relationship b/w automatic thoughts & feelings, in categorizing distorted automatic thoughts, elicit and challenge automatic thoughts, evaluate reasons for and challenge hopelessness, establish no-suicide contract
- Medication
  - Consider meds, evaluate side effects, evaluate need for adjustment
- Homework
  - Have client record thoughts and moods, categorize automatic thoughts, begin self-directed reward planning and activity scheduling, increase self-reward, and use graded task assignments.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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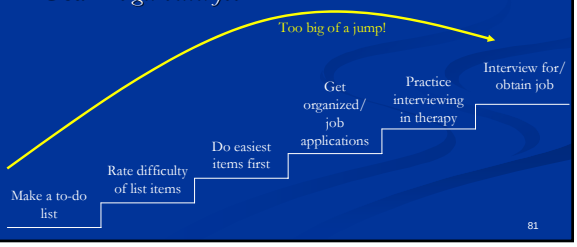
Graded Task Assignment

- Before being ready to face significant challenges, it's often helpful to first master easier ones.
- Goal: *To get better job*



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Sessions 3-4

- Assessment
  - Evaluate homework, evaluate depression and anxiety (and hopelessness), evaluate suicidality, evaluate side effects from medications.
- Behavioral interventions
  - Teach and practice assertion skills, increase rewarding behavior toward others, increase positive social contacts—initiating contact, building support network. Evaluate self-reward, introduce problem-solving skills.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 82

Sessions 3-4

- Cognitive interventions
  - Teach use of daily record of dysfunctional automatic thoughts ("thought record"), use specific cognitive techniques to help client challenge negative automatic thoughts, identify and challenge maladaptive assumptions.
- Medication
  - Evaluate side effects, evaluate need for adjustment.
- Homework
  - Have client use "thought record," assign specific techniques for challenging automatic thoughts and assumptions, continue with graded task assignment, social skills training, reward planning, activity scheduling, problem solving.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 83

Problem-Solving Approach to Depression

1. Identify problem to be solved.
2. Examine costs and benefits of solving problem.
3. List all resources and information available.
4. Generate as many possible solutions, without evaluating these solutions.
5. Rank order the most desirable to least desirable solutions.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 84

Problem-Solving Approach to Depression

6. Develop a plan of action based on the best solution
   - Identify each step in the sequence.
   - Identify resources available for each step.
7. Schedule the first step(s).
8. Evaluate the outcome.
9. Revise the plan, if necessary.
10. Reward yourself for carrying out the steps.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 85

Sessions 5-7

- Assessment
  - Evaluate homework, depression and anxiety, suicidality
- Behavioral interventions
  - Continue to teach and practice problem-solving skills, graded task assignment, assertion and social skills training. Train in communication skills (active listening, editing communication, empathy).

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 86

Sessions 5-7

- Cognitive interventions
  - Identify and challenge automatic thoughts that are particularly difficult for client, and maladaptive assumptions. Begin to identify and challenge negative schemas.
- Medication
  - Evaluate need for reevaluation/adjustment.
- Homework
  - Practice using varying techniques to challenge assumptions and schemas; continue graded task assignment, assertiveness, self-reward, and continue practicing communication and problem solving skills.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 87

Sessions 8-12

- Assessment
  - Evaluate homework, depression and anxiety, suicidality.
- Behavioral interventions
  - Continue to teach and practice problem-solving skills, graded task assignment, assertion and social skills training, communication skills.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 88

Sessions 8-12

- Cognitive interventions
  - Identify and challenge automatic thoughts that are particularly difficult for client, review old ATs and see if they still make sense to client. Examine origin of schemas and evaluate how schemas affected important experiences throughout life.
  - Empty-chair role play to help client challenge negative schemas and people who have been source of those schemas.
  - Help develop more adaptive assumptions and schemas, and develop positive self-statements and "bill of rights"

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 89

Sessions 8-12

- Medication
  - Evaluate need for reevaluation/adjustment.
- Homework
  - Practice using varying techniques to challenge ATs, assumptions, and schemas.
  - develop a list of new, adaptive assumptions and schemas. Write out "bill of rights." Continue graded task assignment, assertiveness, self-reward, and continue practicing communication and problem solving skills.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 90

Session 13-16 (biweekly or monthly)

- Assessment
  - Evaluate homework, depression and anxiety, suicidality, side effects from meds.
- Behavioral intervention
  - Continue to teach & practice problem solving skills, graded task assignment, assertion and social skills training.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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Session 13-16 (biweekly or monthly)

- Cognitive interventions
  - Help to develop more realistic assumptions and schemas
  - Continue to work on positive self-statements and "bill of rights"
  - Review old ATs and continue challenging them
  - Plan termination
  - Have client identify which interventions were helpful and which were not
  - Have client examine previous episodes of depression and describe how depression will be handled in future.
- Homework
  - Develop plan for how problems can be handled in future, self-assign homework, have client indicate which problems will continue to be worked on when therapy ends.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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CBT for Anxiety & PTSD

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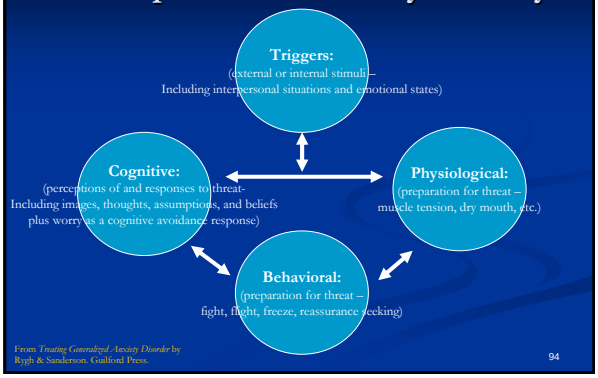
The Experience of Anxiety & Worry



From *Treating Generalized Anxiety Disorder* by Rygh & Sanderson. Guilford Press.

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What is PTSD?

- 3 main types of problems:
  - Reliving the trauma
    - Memories that seem out of control, nightmare, flashbacks
  - Avoiding
    - Try not to think about traumatic event
    - Stay away from people, places, things that are cues
    - Feel numb & detached from others
  - Signs of physical stress
    - Trouble sleeping, feeling irritable, or angry all the time, trouble concentrating, feeling tense/on guard

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Samples Symptoms for PTSD

- Intrusive memories
- Nightmares
- Flashbacks
- Intense distress when exposed to memories/cues
- Avoidance
- Inability to recall parts of trauma
- Withdrawal from usual activities
- Detachment
- Emotional numbness
- Restricted affect
- Inability to imagine the future
- Insomnia
- Irritability
- Anger outbursts
- Impaired concentration
- Hypervigilance
- Startle response

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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Effective Treatments for PTSD

- Once PTSD is diagnosed, Expert Consensus Guidelines recommend two therapies:
  - Exposure therapy
  - Cognitive therapy (which usually includes exposure)
- Exposure therapy can help overcome central behavioral features of PTSD:
  - Avoidance
  - Exposure therapy consists of having the client gradually confront anxiety-producing images and situations associated with the trauma.

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Exposure Therapy for PTSD

- Facing feared stimuli enables one to learn that
  - Anxiety *can* decrease
  - Reminder of the event *can* be tolerated
  - Avoidance is *not* necessary
- Exposure can be imaginal or *in vivo*.
  - Imaginal
    - Present tense retelling of traumatic event
  - *In vivo*
    - Confrontation of actual cues or activities associated with trauma that are being avoided.

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Cognitive Therapy and PTSD

- Why focus on cognitions if exposure therapy is effective?
  - Cognitive therapy includes exposure, but not simply as a method for desensitization.
  - Exposure methods are used to *identify* and *test* key *beliefs* that are linked with maintaining the current PTSD.

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Cognitive Therapy and PTSD

- Why focus on cognitions if exposure therapy is effective? (cont.)
  - New research suggests that the origins of PTSD lie not simply in the occurrence of trauma, but in the *nature of the trauma memory* and *cognitive appraisals* of the trauma and its sequelae.
    - Correlated with whether someone recovers naturally from trauma or develops persistent PTSD.

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Cognitive Model of PTSD

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Cognitive Model of PTSD

- People who experience a natural recovery from trauma are likely to appraise their reactions as…
  - *normal reactions to an abnormal event.*
- Natural recovery is hastened if people…
  - Continue their activities
  - Normalize their trauma-related symptoms
  - Don't avoid reminders of the trauma

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Cognitive Model of PTSD

- People with persistent PTSD tend to view their trauma symptoms as *permanent*.
- PTSD is maintained by:
  - Avoidance (of trauma reminders)
  - Rumination
  - Safety-seeking behaviors
    - Staying home
    - Hypervigilance to danger
- Coherent memories also appear to play a role in PTSD
  - People with PTSD often have a fragmented and disorganized memory of the event.
  - May be related to dissociation as a coping strategy.

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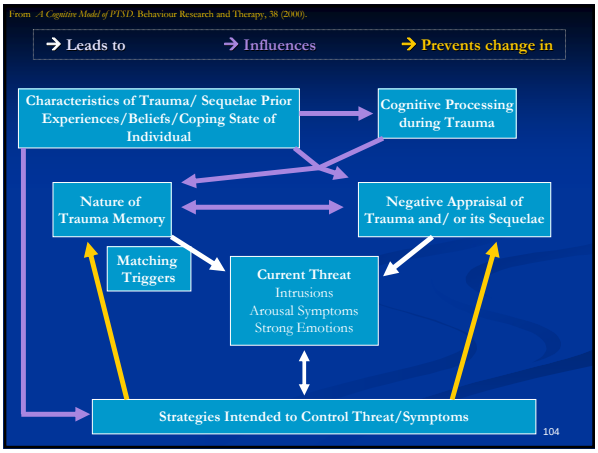

Cognitive Model of PTSD

- Research demonstrating importance of cognitive factors suggests
  - Rather than supportive counseling or repeated retelling of trauma events (in the absence of reframing)…
  - …the most effective therapy for PTSD may be interventions which
    - Test beliefs about long-term effects of trauma and personal trauma responses
    - Help the person organize and complete their trauma memory.

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Examples of Trauma-Related Cognitive Distortions

- "The world is dangerous."
- "Events are unpredictable and uncontrollable."
- "What happened was my fault."
- "I am incompetent."
- "Other people cannot be trusted."
- "Life is meaningless."
- Others?

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 106

Example Techniques for Addressing Trauma-Related Cognitions

- "The world is dangerous"
  1. Calculating probabilities of specific events.
  2. Listing advantages/disadvantages of world view.
  3. Doing a cost-benefit analysis of specific vigilance and avoidance behaviors.
  4. Identifying reasonable precautions.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 107

Example Techniques for Addressing Trauma-Related Cognitions

- "Life is meaningless"
  1. Listing activities that formerly were rewarding
  2. Scheduling pleasurable/rewarding activities
  3. Recognizing feelings of loss as a way of confirming meaning.
  4. Examining which goals and activities no longer seem meaningful and which now appear more important.
  5. Working toward an acceptance of death.
  6. Finding meaning in each day.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 108

Example Techniques for Addressing Trauma-Related Cognitions

- "Other people cannot be trusted"
  1. Listing known persons who are trustworthy, and listing specific ways in which each can be trusted.
  2. Rating people on a continuum of trustworthiness.
  3. Examining a client's history of relationship choices. Are better alternative available?
  4. Carrying out behavioral experiments that involve trusting others in small ways.
  5. Keeping a daily log of people who honor commitments.

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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CBT for PTSD

- 3 steps
  1. Teach coping strategies for feelings and tension associated with memories (relaxation training)
  2. Help to face memories (exposure)
  3. Teach ways to change negative thinking (cognitive restructuring) and handle problems in life (problem solving)
- Contraindications
  - Significant substance abuse, midst of crisis, suicidality, etc.

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General Tx Plan for PTSD

- Assessment
  - Trauma and related symptoms
  - Tests and other evaluations
  - Medication consideration/evaluation
- Socialization to treatment
- Anxiety management training
- Exposure
  - Imaginal exposure to trauma memory & related cues
  - In vivo exposure to avoided situations
- Cognitive restructuring
- Coping with life problems
- Phasing out treatment

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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Sessions 1-2

- Assessment
  - Presenting problems, Hx of trauma, trauma symptoms, relevant background information, rule out contraindications for treatment, assess social supports, etc.
- Socialization to treatment
  - Dx, normalize symptoms, educate about effective treatments (i.e., CBT), discuss medication option, explore concerns about treatment

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 112

Sessions 1-2

- Homework (examples)
  - Monitor trauma triggers
  - Begin listing avoided situations
  - Write out goals for therapy

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 113

Session 3

- Assessment
  - Evaluate homework, evaluate anxiety (BAI, BDI, etc.), assess automatic thoughts, assumptions, and schemas related to trauma
- Socialization to treatment
  - Continue discussing conceptualization of PTSD, discuss advantages/disadvantages of proceeding, obtain consent to proceed

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 114

Session 3

- Coping with life problems
  - Discuss current problems that may interfere with Tx, intervene if possible
- Homework
  - Continue monitoring triggers, avoided situations

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 115

Session 4-6

- Assessment
  - Evaluate homework, evaluate anxiety, assess current coping skills
- Behavioral interventions
  - Teach anxiety management (breathing relaxation, progressive muscle relaxation, visualization, etc.)
  - Have client create list of possible coping strategies

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 116

Session 4-6

- Cognitive interventions
  - Teach client to identify and write automatic thoughts
  - Teach client rational responding
- Homework
  - Same as session 3, assign practice of at least 1 anxiety management technique daily, write automatic thoughts & rational responses

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 117

Session 7

- *Note: May be slightly longer session*
- Assessment
  - Evaluate homework
  - Evaluate anxiety and depression
- Behavioral interventions
  - Create list of imaginal exposure tape, have client listen to tape in session until habituation occurs
- Homework
  - Continue practicing anxiety management techniques, listen to exposure tape daily until habituation occurs

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 118

Session 8-11

- Assessment
  - Same as session 7
- Behavioral interventions
  - Review progress of anxiety management practice and address any problems, continue imaginal exposure until habituation occurs, expose client to cues in session, plan self-directed *in vivo* exposure to avoided situations

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 119

Session 8-11

- Cognitive intervention
  - Note cognitive distortions (at all 3 levels) revealed during exposure, challenge those that do not spontaneously change during exposure
- Homework
  - Practice anxiety management techniques, listen to exposure tape, write automatic thoughts and rational responses, assign self-directed *in vivo* exposure to avoided situations

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 120

Sessions 12-13

- Assessment
  - As in session 7
- Behavioral interventions
  - Encourage continued practice of anxiety management techniques, continue exposure items not completed
- Cognitive interventions
  - Identify problematic cognitions remaining and challenge them

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 121

Sessions 12-13

- Coping with life problems
  - Identify any remaining life problems and teach client appropriate coping skills
- Homework
  - As in 8-11, practice coping strategies for life problems

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 122

Sessions 14-16 (Biweekly or Monthly)

- Assessment
  - As in session 7
- Behavioral interventions
  - Continued practice of anxiety management techniques, continue exposure items not completed, review what's been useful, discuss possible sources of future stress, predict possible temporary renewal of symptoms, discuss ways of coping with them

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford. 123

Sessions 14-16 (Biweekly or Monthly)

- Cognitive interventions
  - Address remaining cognitive distortions, review useful techniques, discuss possible sources of future stress, predict possible temporary renewal of symptoms, discuss ways of coping with them
- Coping with life problems
  - Discuss ways of coping with any remaining life problems
- Homework
  - Self-assign homework, practice anxiety management techniques, self-assigned exposure, cognitive techniques, problem-solving skills; write list of favorite techniques to use after termination

From *Treatment Plans and Interventions for Depression and Anxiety Disorders*. Guilford.

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Clinician Self-Care

To serve those
who protect and serve

--LAPD Chaplain Corps

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What You May Hear

- "You lose some of your humanity in this work."
- "We don't practice what we preach."
- "We're there for clients, but not for each other."

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Clinician Self-Care

- The Occupational Hazard
  - "Vicarious Traumatization"
  - "Secondary Trauma"
  - "Shared Trauma"
  - "Compassion Fatigue"
- By listening empathically to the experience of traumatized people, providers may find their own beliefs challenged and world view changed.

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Clinician Self-Care

- Vicarious Traumatization
  - Be prepared for this effect.
  - Recognize that it is a natural outgrowth of the compassionate connection to intense human suffering.
  - Self care is imperative and effective.

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Clinician Self-Care

- Pay close attention to the following:
  - Monitor your personal reactions to client stories; note when you're feeling overwhelmed.
  - Try not to visualize stories.
  - Set and maintain healthy professional and personal boundaries.
  - Acknowledge the toll of constant exposure to traumatic situations.

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Clinician Self-Care

- Pay close attention to the following (cont.):
  - Balance work with enjoyable personal activities to avoid burnout.
  - Attend to your spiritual needs in a way that is meaningful to you.
  - Enlist the support of your clinical supervisor and/or colleagues when you work with trauma survivors.

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Clinician Self-Care

- Agencies and organizations:
  - Warn and protect staff against vicarious traumatization.
  - Offer appropriate support, supervision, consultation.
  - Limit the number of trauma cases per caseload.
  - Provide continuing education on topic as needed.

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Clinician Self-Care

- In cases of shared trauma (Katrina)
  - Clinicians should open themselves up to own fears and terrors
  - In reality, both client and clinician are dealing with painful process of loss, mourning, and need for reconstruction.
  - Both client and clinician need to develop a world view that accommodates the new reality.
  - Though painful and frightening, the process contains within it the seeds of greater awareness, personal growth, and wisdom.

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Related Resources

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Recommended Books

- Beck. *Cognitive Therapy: Basics and Beyond.*
- Beck. *Cognitive Therapy for Challenging Problems.*
- Follette, Ruzek, & Abueg. *Cognitive-Behavioral Therapies for Trauma.*
- Greenberger & Padesky. *Mind Over Mood.*
- Hays & Iwasama. *Culturally Responsive Cognitive-Behavioral Therapy.*
- Leahy & Holland. *Treatment Plans and Interventions for Depression and Anxiety Disorders.*
- Padesky & Greenberger. *Clinician's Guide to Mind Over Mood.*
- Persons. *Cognitive Therapy in Practice: A Case Formulation Approach.*
- Rygh & Sanderson. *Treating Generalized Anxiety Disorder: Evidence-Based Strategies, Tools, and Techniques.*
- Williams & Poijula. *The PTSD Workbook.*

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General Resources

- Academy of Cognitive Therapy
  - www.academyofct.org
- The Anxiety Disorders Association of America
  - www.adaa.org
- Association for Behavioral and Cognitive Therapies
  - www.aabt.org
- Beck Institute for Cognitive Therapy and Research
  - www.beckinstitute.org
- The International Society for Traumatic Stress Studies
  - www.istss.org
- National Center for PTSD
  - www.ncptsd.va.gov (including PILOTS database)

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CBT Outcome Review Articles

- Butler, A.C., Chapman, J.E., Forman, E.M., & Beck, A.T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26(1),* 17-31.
- Chambless, D.L., & Ollendick, T. H. (2001). Empirically Supported Psychological Interventions: Controversies and Evidence. *Annu. Rev. Psychol, 52,* 685-716.

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CBT Principles and Techniques for Stress-Related Reactions

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